

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G237 12-19-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

14410

14424

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(rural) Berlin</b>		c. LENGTH OF STAY IN TB <b>all her life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route # 3</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Berlin (rural)</b>	
3. NAME OF DECEASED (Type or print) <b>Maggie</b> First <b>E.</b> Middle <b>Ayres</b> Last		4. DATE OF DEATH <b>12</b> Month <b>3</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>FM</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.	IF UNDER 24 HRS. Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factories</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Briddell</b>		14. MOTHER'S MAIDEN NAME <b>Susan Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>John E. Fitchett, 1247 S. 47th St, Phila., Pa.</b>	
17. INFORMANT <b>John E. Fitchett, 1247 S. 47th St, Phila., Pa.</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>332 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential hypertension</b> DUE TO <b>Atherosclerosis</b> (c) <b>Interval between onset and death</b> <b>1 week</b> <b>Several years</b> <b>2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 12-55</b> , to <b>12-3-58</b> , that I last saw the deceased alive on <b>12-2-58</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Berlin, Md.</b> DATE SIGNED <b>12/6/58</b>			
ACTUAL SIGNATURE <b>Henry M. Sully, Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. I. U. Sully, Jr., M.D.</b> <b>Berlin, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/7/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berlin, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home, Salisbury, Md</b> ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 10 '58</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Cuthbert S. Thomas</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14421

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3,7 FilmG237 12-30-58 et

14411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Pocomoke City MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1414 Oxford St</u>	
3. NAME OF DECEASED (Type or print) <u>Wm</u> First <u>Jules</u> Middle <u>Clay</u> Last <u>Cley</u>		DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29 - 1890</u> 68 yrs.
9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Street cleaner for Pocomoke City, Md</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MARRIED NAME <u>Eliza Swales</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes 1917-1919</u>	
16. SOCIAL SECURITY NO. <u>212-07-1869</u>		17. INFORMANT <u>Alberta Shoolfield</u> Address <u>Pocomoke City</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Accident</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Two hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Strapped 35 years by a car on Oct 5, 1958 on street</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>100moke Worcester MD</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		ADDRESS <u>DEC 18 '58</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. MEDICAL HISTORY		10. PHYSICAL EXAMINATION		11. LABORATORY EXAMINATIONS		12. POSTMORTEM FINDINGS	
13. MEDICAL OPINION		14. SIGNATURE OF EXAMINER		15. DATE OF CERTIFICATE		16. PLACE OF CERTIFICATE	

RECEIVED  
BUREAU OF VITAL RECORDS  
JAN 10 1911

14422

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> <b>Worcester</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				d. STREET ADDRESS <b>R.F.D. #2 Box 32</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Elton Randolph Coston</b>				4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27, 1917</b>		9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Auto.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Moses Coston</b>				14. MOTHER'S MAIDEN NAME <b>Abie Rolley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-18-4920</b>		17. INFORMANT <b>Wilsie Coston, Pocomoke City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastases in Brain</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 31, 1957</b> to <b>Dec 31, 1958</b> , that I last saw the deceased alive on <b>Dec 30, 1958</b> , and that death occurred at <b>2:22 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Paul Brey M.D. Snow Hill Md 1-3-59</b>							
ACTUAL SIGNATURE			PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Georgetown, Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Wharton - New Church, Va.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONSON		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1880		5. PLACE OF BIRTH New York	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH 1925	
11. SIGNATURE OF DECEASED James J. Jonsen		12. SIGNATURE OF WITNESSES John J. Jonsen		13. SIGNATURE OF PHYSICIAN Dr. J. J. Jonsen		14. SIGNATURE OF CLERK J. J. Jonsen		15. SIGNATURE OF REGISTRAR J. J. Jonsen	
16. NAME OF FUNERAL HOME J. J. Jonsen		17. NAME OF BURIAL PLACE J. J. Jonsen		18. NAME OF CEMETERY J. J. Jonsen		19. NAME OF CHURCH J. J. Jonsen		20. NAME OF MINISTER J. J. Jonsen	
21. NAME OF NEXT OF KIN J. J. Jonsen		22. NAME OF SURVIVORS J. J. Jonsen		23. NAME OF DECEASED'S MOTHER J. J. Jonsen		24. NAME OF DECEASED'S FATHER J. J. Jonsen		25. NAME OF DECEASED'S SISTER J. J. Jonsen	
26. NAME OF DECEASED'S BROTHER J. J. Jonsen		27. NAME OF DECEASED'S UNCLE J. J. Jonsen		28. NAME OF DECEASED'S AUNT J. J. Jonsen		29. NAME OF DECEASED'S NEPHEW J. J. Jonsen		30. NAME OF DECEASED'S NIECE J. J. Jonsen	
31. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		32. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		33. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		34. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		35. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen	
36. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		37. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		38. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		39. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		40. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen	
41. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		42. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		43. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		44. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		45. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen	
46. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		47. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		48. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		49. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		50. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen	
51. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		52. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		53. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		54. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		55. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen	
56. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		57. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		58. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		59. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		60. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen	
61. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		62. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		63. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		64. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		65. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen	
66. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		67. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		68. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		69. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		70. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen	
71. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		72. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		73. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		74. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		75. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen	
76. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		77. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		78. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		79. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		80. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen	
81. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		82. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		83. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		84. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		85. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen	
86. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		87. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		88. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		89. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		90. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen	
91. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		92. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		93. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		94. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		95. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen	
96. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		97. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		98. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen		99. NAME OF DECEASED'S GRANDFATHER J. J. Jonsen		100. NAME OF DECEASED'S GRANDMOTHER J. J. Jonsen	



1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

14412

14423

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Worcester</b>		STATE <b>MARYLAND</b>		STATE <b>Virginia</b>		COUNTY <b>Accomac</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b>		LENGTH OF STAY (in this place) <b>1 year</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Parksley</b>		TOWN <b>Parksley</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Redden Nursing Home</b>				STREET ADDRESS (If rural give location) <b>RFD</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Sally</b> (Middle) <b>Pate</b> (Last) <b>Ewell</b>				(Month) <b>Dec.</b> (Day) <b>10,</b> (Year) <b>58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWER, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1867</b>	9. AGE last birthday <b>91</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Parksley, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred J. Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Maria (last name unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Son John Ewell</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>						30 Min.	
ANTECEDENT CAUSE(S) DUE TO <b>Generalized Arteriosclerosis</b>						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Convulsive seizures of unknown origin</b>						Years.	
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan. 3, 1958</b> , to <b>Dec. 10, 1958</b> , that I last saw the deceased alive on <b>Dec. 10, 1958</b> , and that death occurred at <b>520P</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Charles W. Trader</b>				ADDRESS (Street, city, town, state) <b>302 Market St., Pocomoke City, Md.</b>		DATE SIGNED <b>12/10/58</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12/12/58</b>		NAME OF CEMETERY OR CREMATORY <b>Liberty</b>		LOCATION (City, town, or county) (State) <b>Parksley Va</b>	
24. REC'D BY REGISTRAR <b>DEC 18 '58</b>		REGISTRAR'S SIGNATURE <b>Charles W. Trader</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Henry M. Johnson</b>		ADDRESS	

# CERTIFICATE OF DEATH

FILE NO.

COUNTY OF <u>ALLEGANY</u> TOWNSHIP OF <u>ALLEGANY</u> CITY OF <u>ALLEGANY</u>		COUNTY OF <u>ALLEGANY</u> TOWNSHIP OF <u>ALLEGANY</u> CITY OF <u>ALLEGANY</u>	
DECEASED <u>ALLEGANY</u> AGE <u>ALLEGANY</u> SEX <u>ALLEGANY</u> OCCUPATION <u>ALLEGANY</u>		DECEASED <u>ALLEGANY</u> AGE <u>ALLEGANY</u> SEX <u>ALLEGANY</u> OCCUPATION <u>ALLEGANY</u>	
DATE OF DEATH <u>ALLEGANY</u> TIME OF DEATH <u>ALLEGANY</u>		DATE OF DEATH <u>ALLEGANY</u> TIME OF DEATH <u>ALLEGANY</u>	
PLACE OF DEATH <u>ALLEGANY</u> CAUSE OF DEATH <u>ALLEGANY</u>		PLACE OF DEATH <u>ALLEGANY</u> CAUSE OF DEATH <u>ALLEGANY</u>	
SIGNATURE OF PHYSICIAN <u>ALLEGANY</u> SIGNATURE OF CORONER <u>ALLEGANY</u>		SIGNATURE OF PHYSICIAN <u>ALLEGANY</u> SIGNATURE OF CORONER <u>ALLEGANY</u>	
CERTIFICATE OF DEATH I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health.		CERTIFICATE OF DEATH I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health.	

RECORDS SECTION

1. The death certificate is a legal document which is required by law to be filed with the records section of the Department of Health. It is a document which is used to determine the cause of death and to determine the time and place of death. It is also used to determine the age and sex of the deceased. The death certificate is a document which is used to determine the cause of death and to determine the time and place of death. It is also used to determine the age and sex of the deceased.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14425 CERTIFICATE OF DEATH

14413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>			
c. LENGTH OF STAY IN TB <b>All his life</b>				d. STREET ADDRESS <b>Route # 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route # 2</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elwood</b> Middle <b>Fooks</b> Last <b>Fooks</b>				4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>AA.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 11, 1905</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>5</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>12</b> Days <b>5</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painting</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>MARYLAND</b>			
13. FATHER'S NAME <b>Lambert Fooks</b>				14. MOTHER'S MAIDEN NAME <b>MARY IDA SMACK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-32-9845</b>			
17. INFORMANT <b>Mrs. ELIZA Fooks, Berlin, Md.</b>				Address <b>Rt # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of larynx with metastases</b> 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>13 mos</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-15, 1955</b> , to <b>12-5, 1958</b> , that I last saw the deceased alive on <b>12-4, 1958</b> , and that death occurred at <b>4:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. J. U. Sully</b> M.D.				ADDRESS (Street, city or town, state) <b>Berlin, Md.</b>			
PHYSICIAN'S NAME (Type) <b>DR. J. U. Sully</b>				DATE SIGNED <b>12/6/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>12-8-58</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Berlin, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. STEWART FUNERAL HOME, Salisbury, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 10 '58</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
WATERGATE		JAN 21 1962	
RESIDENT		AGE	
FEMALE		44	
RACE		WHITE	
MARRIED		HUSBAND	
FATHER		MOTHER	
BORN		DIED	
JAN 21 1962		JAN 21 1962	
TIME OF DEATH		PLACE OF DEATH	
12:30 PM		WATERGATE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
CORONARY ARTERY DISEASE		SUICIDE	
MURDER		ACCIDENT	
OTHER		OTHER	
SIGNED		WITNESSED	
J. M. Sullivan		J. M. Sullivan	
DATE		DATE	
JAN 21 1962		JAN 21 1962	
PLACE OF DEATH		DATE OF DEATH	
WATERGATE		JAN 21 1962	
RESIDENT		AGE	
FEMALE		44	
RACE		WHITE	
MARRIED		HUSBAND	
FATHER		MOTHER	
BORN		DIED	
JAN 21 1962		JAN 21 1962	
TIME OF DEATH		PLACE OF DEATH	
12:30 PM		WATERGATE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
CORONARY ARTERY DISEASE		SUICIDE	
MURDER		ACCIDENT	
OTHER		OTHER	
SIGNED		WITNESSED	
J. M. Sullivan		J. M. Sullivan	
DATE		DATE	
JAN 21 1962		JAN 21 1962	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**14426 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14414

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Worcester</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> c. LENGTH OF STAY IN 1b <u>all his life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route # 2</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> d. STREET ADDRESS <u>Route # 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>FRANKLIN</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>15</u> Year <u>1958</u>					
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>AA</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-14-1893</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>COOK</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RESTAURANT</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Will FRANKLIN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Pitts</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>165-07-5588</u>		<b>17. INFORMANT</b> Address <u>MRS. Emma Conrad - Berlin, Md</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Degenerative Myocarditis &amp; Atherosclerosis</u> <u>420.1</u> DUE TO (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sartre Resection &amp; Sartre Enterostomy</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5-6 days</u> <u>2 yrs</u>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>Hermon A. Robbins</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				<b>DATE SIGNED</b> <u>12/15/58</u>					
<b>EXAMINER'S NAME</b> (Type) <u>Hermon A. Robbins M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>12-20-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>EVERGREEN CEMETERY</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>BERLIN MD</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J.E. Stewart</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DEC 19 58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Physician	
13. Signature of Nurse		14. Signature of Chaplain		15. Signature of Minister	
16. Signature of Undertaker		17. Signature of Burial		18. Signature of Cremation	
19. Signature of Other		20. Signature of Other		21. Signature of Other	
22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other	
28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other	
34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other	
40. Signature of Other		41. Signature of Other		42. Signature of Other	
43. Signature of Other		44. Signature of Other		45. Signature of Other	
46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other	
52. Signature of Other		53. Signature of Other		54. Signature of Other	
55. Signature of Other		56. Signature of Other		57. Signature of Other	
58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other	
64. Signature of Other		65. Signature of Other		66. Signature of Other	
67. Signature of Other		68. Signature of Other		69. Signature of Other	
70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other	
76. Signature of Other		77. Signature of Other		78. Signature of Other	
79. Signature of Other		80. Signature of Other		81. Signature of Other	
82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other	
88. Signature of Other		89. Signature of Other		90. Signature of Other	
91. Signature of Other		92. Signature of Other		93. Signature of Other	
94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other	
100. Signature of Other		101. Signature of Other		102. Signature of Other	

NOV 10 1910

RECEIVED  
NOV 10 1910  
DEPT. OF HEALTH  
ALBANY, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14427 CERTIFICATE OF DEATH

Reg. Dist. No. 14415

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Sallie</u> First <u>M.</u> Middle <u>Hall</u> Last				4. DATE OF DEATH <u>Dec.</u> Month <u>14</u> Day <u>1958</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Showell, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin Showell</u>				14. MOTHER'S MAIDEN NAME <u>Ediza Showell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Ella Purnell</u> Address <u>Bishop, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592x Acute Myocarditis</u> DUE TO <u>Chr. Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 15 - 1958</u> , to <u>Dec 14 - 1958</u> , that I last saw the deceased alive on <u>Dec 14 - 1958</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas R. Law</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>12-15-58</u>			
PHYSICIAN'S NAME (Type) <u>-</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Showell</u>		22d. LOCATION (City, town, or county) (State) <u>Showell Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF TOWNSHIP CLERK</p>		<p>20. SIGNATURE OF VOTING CLERK</p>	

MAINE STATE DEPARTMENT OF HEALTH - BATHING, 18



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14416

Reg. Dist. No.

14428

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>54 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pocomoke City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EURAH M. HILL</b>				4. DATE OF DEATH Month Day Year <b>December 21, 19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1868</b>	9. AGE (In years last birthday) yrs. <b>90</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Outten</b>				14. MOTHER'S MAIDEN NAME <b>Sally Gootie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Charles W. Hill, Rural Pocomoke City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 21, 1958</b> , to <b>Dec 21, 1958</b> , that I last saw the deceased alive on <b>Dec 21, 1958</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>C. E. Critcher</b> M.D. <b>Charles W. Hill</b> PHYSICIAN'S NAME (Type) <b>C. E. CRITCHER</b> <b>NEW CHURCH</b> <b>VIRGINIA</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-23-58</b>		22c. NAME OF CEMETERY <b>Goodwill Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Pocomoke City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>				ADDRESS <b>Pocomoke City, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 24 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles W. Hill</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14429

CERTIFICATE OF DEATH

14417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whayleville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whayleville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village		d. STREET ADDRESS In Village	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle KIRBIN Last MITCHELL		4. DATE OF DEATH Month DECEMBER Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Single <input checked="" type="checkbox"/> FORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Employed)		10b. KIND OF BUSINESS OR INDUSTRY Willards, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ernest F. Mitchell		14. MOTHER'S MAIDEN NAME Gertrude E. Dennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes. W.W.II		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Edward D. Mitchell (Brother) 320 Poplar Hill Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocarditis 592X DUE TO (b) Chronic Interstitial Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-1958, to 12-25-1958 that I last saw the deceased alive on Dec. 22, 1958, and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford E. Schott		DATE SIGNED December 26-1958	
PHYSICIAN'S NAME (Type) Dr. Clifford E. Schott		ADDRESS (Street, city or town, state) 310 N. Main St. Berlin, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 28, 1958	22c. NAME OF CEMETERY OR CREMATORY Dennis Family Cemetery R.D. # Willards, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE DEC 31 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14418

14430

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin - Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>RR 2 D</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Alexander</u> Last <u>Simmons</u>		4. DATE OF DEATH <u>Dec</u> Month <u>20</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 21 - 1947</u>
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	11. BIRTHPLACE (State or foreign country) <u>Beauford NC</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Clarence Alexander Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Palmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Ethel Palmer - Berlin MD</u>		Address <u>RR 2 D</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>fractured skull, broken neck</u> 816X DUE TO (b) <u>Auto - accident</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deceased in family Chevrolet car driven by mother/deceased have into the path of a Cadillac and was thrown out.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>fracturing in above injuries with instant death</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-20-58</u> Hour a. m. <u>2:15</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Berlin</u> (County) <u>Worcester</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius Sr</u>		DATE SIGNED <u>12/21/58</u>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	22d. LOCATION (City, town, or county) <u>Berlin</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ann A Burbage</u>		ADDRESS <u>Berlin MD</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. House</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	
DATE <u>DEC 29 '58</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14431 CERTIFICATE OF DEATH

Reg. Dist. No. 14419

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>M.</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19 - 1883</u>
9. AGE (In years, last birthday) <u>75 6/11</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Williams</u>		14. MOTHER'S MAIDEN NAME <u>Baroline Maddox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Matthew S. Taylor, Newark, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular</u> DUE TO <u>renal disease</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>many years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-5-58</u> , 19 <u>58</u> , to <u>12-6-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-5-58</u> , 19 <u>58</u> , and that death occurred at <u>12-6-58</u> , M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Brown</u> M.D.		ADDRESS (Street, city or town, state) <u>Snow Hill Md</u> DATE SIGNED <u>12-8-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> <u>Dec 9/58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Gimmis</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>	

CERTIFICATE OF DEATH

WILLIAM BONE

MALE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN